

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-016835

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 217

Primary Registration District No. 3045

Registrar's No. 51

STATE FILE NUMBER

FILED APR 25 1963

1. PLACE OF DEATH a. COUNTY <u>Mississippi</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Miss.</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>OR</u> <u>Charleston</u>		c. CITY OR TOWN <u>Charleston</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence</u>		d. STREET ADDRESS (If outside, give location) <u>906 W. Marshall</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Clyde</u> Middle <u>William</u> Last <u>Anderson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/27/96</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rt. Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>	11. BIRTHPLACE (City and state or country) <u>E. Prairie, Mo.</u>
13a. FATHER'S NAME <u>John Anderson</u>		13b. MOTHER'S MAIDEN NAME <u>George Ann Wilson</u>	14. NAME OF HUSBAND OR WIFE <u>Bessie Hogan Grimes</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates) <u>No</u>		17. INFORMANT Address <u>Jack Anderson, Sikeston, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Car Pulmonary</u> DUE TO (b) <u>Bronchiectasis & Emphysema</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Super imposed H.R. Infection (acute)</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION	COUNTY _____ STATE _____
21. I attended the deceased from <u>3/25/63</u> to <u>4/16/63</u> and last saw him alive on <u>4/16/63</u> Death occurred at <u>5:40 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>E. Charles Palmering M.D.</u> (Degree or title)		22b. ADDRESS <u>Charleston, Mo.</u>	22c. DATE SIGNED <u>4/16/63</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4/18/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dexter Cemetery</u>	23d. LOCATION (City, town, or county) <u>Dexter, Missouri</u>
24. FUNERAL DIRECTOR <u>McMikle, Charleston, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4-18-63</u>	26. REGISTRAR'S SIGNATURE <u>Norady B. Hawthorn</u>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK

OR

TYPEWRITER RIBBON

VS 300
Rev. 4/59

DATE AMENDED

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APR 26 1963

Permit issued
4-24-63
JCH

STATEMENT BY LICENSED EMBALMER

0-02

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Bruce R. Huston

Licensed Embalmer No. 5149

P. O. Address East Prairie, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.